Printed: 12/10/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI		1 1	CONSTRUCTION	(X3) DATE S COMPLE	
		17E630		B. WING		12/	10/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE,	ZIP CODE		
ANTHONY COMMUNITY CARE CENTER			212 N 5 ANTHO	TH AVE NY, KS 67003			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3		F 000			
		ents the findings of a Henry and complaint # 72094.	ealth				
	483.20(b)(2)(ii) COM AFTER SIGNIFICAN	PREHENSIVE ASSES T CHANGE	S	F 274			
	facility determines, or that there has been a resident's physical or purpose of this section means a major declir resident's status that itself without further in implementing standa interventions, that had one area of the residence interdiscipling care plan, or both.) This Requirement is The facility census to included in the sample comprehensive assessible observation, interview	dent within 14 days after should have determine a significant change in the mental condition. (For on, a significant change he or improvement in the will not normally resolventervention by staff or the disease-related clinics an impact on more the ent's health status, and harry review or revision of the with one review for ssment. Based on wand record review the	ed, he re ee ee oy cal han of the				
	for a resident with a	comprehensive assessi significant change.(#3)					
	Findings included:						
	Admission date 10/22	2/14					
	MDS (minimum data the resident had long memory impairment. extensive assistance	ent #3's comprehensive set) dated 8/31/14 reve term and short term The resident required with ADLs (activities of acontinent of bowel and	ealed of daily				
LABORATOR'	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATI\	E'S SIGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER		` ′	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
		17E630		B. WING	 	12/10/	/2014
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER			STREET ADDR 212 N 51 ANTHON				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID	I .	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 274	Continued From pag bladder	e 1		F 274			
	,	care area assessment) did not have a CAA the hospice.	at had				
	Review of the resident's care plan, initiated 8/28/14, revealed a new order for a hospice consult if the family wished. The residents family was making the decision. His/her family wished for him/her to have strict comfort care. The family wished for the staff to manage the resident's pain, but did not wish for any further testing.						
	11/12/14, revealed the chosen hospice to put the facility, for the results Staff were to observe signs of pain, administration	nt's care plan, initiated to residents family had rovide end of life care with sident's comfort and dige the resident closely for ster pain medications a hysician immediately if gh pain.	nity. r s				
	Hospice physician or diagnosis of renal fai	der dated 11/11/14 revellure	ealed				
	talked with the charg the resident had any was at the facility twi	M revealed hospice nur e nurse about whether change. The hospice n ce a week and hospice well. Hospice had supp	or not urse aide				
		strative nursing staff B M revealed MDS signi	I .				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
AND PLAN O	CORRECTION	IDENTIFICATION NUMBE	K.	A. BUILDING	' <u></u>	COMPLETE	:υ	
	17E630			B. WING		12/10	/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
ANTHON	COMMUNITY CARE	CENTER		TH AVE NY, KS 670	03			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE	JLD BE	(X5) COMPLETION DATE	
F 274	Continued From page	e 2		F 274				
	change needed to ha ARD (assessment rev that the significant ch the care plan had bee Interview with adminis 12/03/2014 at 9:26 Al are updated every qu	ve 14 days to complete view date). He/she is avange was not complete en updated for. strative nursing staff B of M revealed the care pla arter, annually, fall skin	vare d but on ins					
	issues, antibiotic and significant change . MDS are triggered by ARD date and need to be completed within 10 days once it had been triggered. Facility failed to provide policy regarding							
	comprehensive assessment. The facility failed to develop a comprehensive assessment for resident #3 reflecting the need for hospice services.							
F 279 SS=D	483.20(d), 483.20(k)(COMPREHENSIVE C			F 279				
		e results of the assessm d revise the resident's of care.	nent					
	plan for each resident objectives and timeta medical, nursing, and	elop a comprehensive of t that includes measura bles to meet a resident' mental and psychosoc ied in the comprehensiv	ble 's cial					
	to be furnished to atta highest practicable ph psychosocial well-bei §483.25; and any ser be required under §48	-	lent's vise ded					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPP IDENTIFICATION I			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/10	0/2014
	OVIDER OR SUPPLIER			ESS, CITY, STAT	TE, ZIP CODE		
ANTHON	Y COMMUNITY CARE	CENTER	212 N 51 ANTHOI	NY, KS 670	03		
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F 279	§483.10, including th under §483.10(b)(4).	e right to refuse treatme		F 279			
	The facility reported 16 in the sample. Ba interview, and record develop comprehens	a census of 29 resident sed on observation, I review the facility failed sive care plans for 2 of 2 In to hospice services ar	s with				
	MDS (Minimum Data a BIMS (Brief Intervie of 01, indicating several He/she did not exhibit required extensive as mobility. He/she use mobility. The assess had an unstageable tissue loss of a localify underlying tissue usuas a result of pressur combination with she the actual depth of the dead tissue) present had a pressure relieved device, was on a turn	#20's significant change a Set) dated 1/27/14 review for Mental Status) so the cognitive impairment it rejection of care. He/sesistance of 1 staff for the day and wheelches are the comment indicated the residence of injury to the skin are ually over a bony prominer, or pressure in the wound was obscured on admission. The residence on admission. The residence of the comment indicated injury to the skin are ually over a bony prominer, or pressure in the wound was obscured on admission. The residence on admission. The residence of the comment in the comment	realed core it. she bed air for dent kness ind/or inence, the by dent am,				
	(Care Area Assessm the resident had an a wound to the back of #20 returned from the Daily monitoring and wound were done. R	20's Pressure Ulcer CA ent) dated 2/10/14 reverse actual unstageable presof his/her left heel. Reside hospital with the wour weekly assessments of the esident #20 had a presois/her feet were off-load	ealed esure ent nd. f the sure				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/	10/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ANTHON	Y COMMUNITY CARE	CENTER	212 N 5 ANTHO	TH AVE NY, KS 670	03			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 279	well. Resident #20 was potential of wounds as feel pressure. Reside medication which coube as aware of the nedecreased mobility are cause decreased resignation. Review of the quarter revealed a BIMS score cognitive impairment. rejection of care. He/s assistance of 1 staff frassessment indicated assistive device for munitageable pressure resident had a pressure resident was on a program, and had pressure resident was an analysis of interventions included ordered, heel to be of he/she wore compress The care plan was not types of interventions #20's heel was off-load revealed a score of 2 11:47 a.m. with admir revealed a score of 1 resident was at risk for r	as unable to understand and had decreased abilition #20 did take antianxial cause the resident need to move. The resident of circulation difficulty opense to pressure. His/le to being in bed and and the MDS dated 10/30/14 for end of 1, indicating several to be did not exhibit the required extensive for bed mobility. The did the resident did not us abbility. The resident had a culcer on admission. The relieving mattress are a turning/repositioning resure ulcer care. 20's care plan dated 1/3 returned from the hosp wound to his/her left here in place to ensure resident and the providing treatment as ff-loaded at all times, are sign stockings for eden at specific to identify the in place to ensure resided. Scale score done 10/25/11. An interview on 12/4/nistrative nursing staff Ele or less indicated the or pressure ulcers.	ty to lety oot to ent's could her ere let an dan he had oo/14 lital let. So had had. Ital let. So had had had let. So had had let. So had had let. So had had let let. So had had let	F 279				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPP IDENTIFICATION I		CLIA		ILDING		(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/1	0/2014	
	OVIDER OR SUPPLIER	OFNITED	STREET ADDR		TE, ZIP CODE			
ANTHON	COMMUNITY CARE	CENTER	212 N 51 ANTHON	NY, KS 670	03			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	I .	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	Continued From pag	ge 5		F 279				
	Review of a Braden revealed a score of	Scale score done 4/29/ ⁻ 19.	14					
	Review of a Braden revealed a score of	Scale score done 10/30 19.	/14					
	revealed the residen and dark red drainag patted dry and an off The area measured	ound Note dated 1/29/14 t's left heel had a loose ge. The area was cleans f-load dressing was app 1 cm (centimeter) by 1.9 edges. The surrounding 1 dry.	scab sed, lied. 5 cm					
	p.m4:30 p.m. reside his/her room with the	on on 12/2/14 from 3:00 ent #20 sat in the recline e footrest in the up posit g off the edge of recline	ion					
	resident #20 rested of At 7:46 a.m. direct coresident's room and body, resident #20's bed and not off-loade had an area of brown approximately 2 cm a.m. the resident sat	on on 12/3/14 at 7:28 a.r on his/her back while in are staff H entered the uncovered his/her lower heels were resting on the ed. Resident #20's left hen-purple discoloration by 2 cm with dry skin. At in his/her recliner in his otrest in the up position of g off the foot rest.	r ne neel t 8:59					
	care staff J reported his/her left foot, but h was a pressure ulcer resident had some k heels off the bed use J reported while the	on 12/3/14 at 9:37 a.m. resident #20 had an are ne/she was unsure if the r. Staff J reported the ind of cushion to lift his/ed at night while in bed. resident sat in the reclin/her feet rested off the	ea on e area her Staff					

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	ROVIDER OR SUPPLIER	•		ESS, CITY, STAT	TE, ZIP CODE		
ANTHON	ANTHONY COMMUNITY CARE CENTER			TH AVE NY, KS 6700	03		
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F 279	footrest. Staff J confice (electronic care plan resident's heels were but it did not identify the boot, cushion, or did not rest on the food not rest on the food not rest on the food in his/her left foot at nigpropped up with hee folded in half. Staff I was in the recliner his position and his/her edge. He/she reporte the resident to ambut Staff I reported he/shin place for the resident to ambut Staff I reported he/shin place for the resident were on the care pla confirmed the karden heel was to be off-loan to state the specific During an interview of licensed nursing staff a pressure ulcer to halmost healed. Staff included to off-load that night while in bed, points of pressure whand bed. Staff E repounder the resident's confirmed the care phecomes at all times specific interventions. During an interview of administrative nursin #20's left heel was moff-loaded. He/she resident.	rmed on the kardex accessible to the aides at the specific intervention ensuring the resident's otrest of the recliner. On 12/3/14 at 2:27 p.m. resident #20 wore a body thand his/her feet were also off the bed with a pillor reported while the resident was in the feet were to hang off the ed he/she also encourage late to prevent pressure the thought the intervention. At 2:50 p.m. staff I is identified resident #20 aded at all times, but it is	direct of on elections direct of on elections direct of on elections direct of on elections direct of one elections direct one election	F 279			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER			212 N 51	ESS, CITY, STA FH AVE NY, KS 670			
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F 279	the comprehensive or resident's heel was to Staff E confirmed the boot needed to be or Review of the facility' Care Plans dated 07/developed a comprel resident that included a timetable to meet a and mental and psycothe comprehensive a was developed according interdisciplinary team. The facility failed to do care plan that identification that identification in the sident #20's left heep comprehensive and the sident #20's left heep care in the sident #20's left heep	are plan indicated the be off-loaded at all tine interventions of left for the care plan. Is policy for Compreher/2001 revealed the facily measurable objectives a resident's medical, nuthosocial needs identified seesment. The care profing to regulations by a to the extent practicable levelop a comprehensive dinterventions to care	estive ity ach s and rsing, ed in lan an le.	F 279			
	MDS (minimum data resident had long ten impairment. The resident assistance with two sectivities of daily living bowel and bladder. Review of the resident 8/28/14, revealed and consult if the family we was making the decist for him/her to have sections.	ent #3's comprehensive set) dated 8/31/14 rev m and short term memodent required extensive staff members for ADLs ng). He/she is incontined the scare plan, initiated new order for a hospice vished. The residents fasion. His/her family wish trict comfort care. The formanage the resident's ny further testing.	ealed ory int of amily amily amily				
	Review of the resider	nt's care plan, initiated					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER Y COMMUNITY CARE	CENTER	212 N 5	RESS, CITY, STA TH AVE NY, KS 670			
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F 279	11/12/14, revealed the chosen hospice to put the facility, for the resistaff were to observe signs of pain, administ ordered, and notify put had been breakthrous. Review of the resider care plan did not desible furnished by hospical dated 11/19/14 at 1:3 held a Care Plan merof the family came to resident was being as been discussed with. Observation on 12/03 the resident was rest and covered with bland. Observation on 12/03 hospice aide there to linterview with direct of 10:03 AM revealed in Tuesay and Thursds would provided baths. Wednesday. The hospice in the facility. To look and see where facility to provide care.	e residents family had rovide end of life care was ident's comfort and dig the resident closely for ster pain medications as hysician immediately if gh pain. It's care plan revealed the cribe the services that a ice to attain and maintal services Progress Note 19 p.m. revealed the stateting for the resident. Note the care plan meeting, dmitted to hospice it has family. 2/14 at 3:01 PM revealing in recliner with oxygonket. 3/14 at 8:58 AM revealed give resident a shower care staff K on 12/4/14 esident received baths asy from hospice. The factor of Monday and spice brought the supplication of know when hospice the staff was unaware we hospice was to be in the staff was unaware was the staff was unaware was to be in the staff was unaware was	nity. sthere the are to in effone The d ed en on d at on cility es for e had there the	F 279			

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANTHON	Y COMMUNITY CARE	CENTER		TH AVE NY, KS 670	03			
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F 279	do not know when ho sometime hospice ha second. The nurse so they had been there. resident had been rec what hospice was prodetermine what service when reviewing the control of the provided service with direct of 9:10 AM reavealed that a week to give showe been changed. Interview with licenses 12/03/2014 at 2:41 Plated with the charge with resident. The host facility twice a week at a week. Staff revealed medication and supplementation and supplementation and supplementation with the hospice whether or not hopice supplies. He/she wou hospice cames in the example baths. The coupdated every quarted antibotic and significant Review of the facility care plans, last revise facility will develop a seach resident that inconfiguration objectives and timetal medical, nursing and	spice has been there is been there on first or ometime let staff know with the careplan just listed beiving hospice and not oviding. Staff was unable to hospice was providing are plan. The careful was unable to hospice was providing are plan. The tare staff H on 2/03/14 that hospice came out twenty and then the days have a spice nurse about any change and that hospice aide came defined that hospice supplied ites. The tare staff E on the wind hospice aide came defined that hospice aide came defined that hospice aide came defined he/she was revices are provided as a provide medication and all did care plan how often facility to provide care are plans need to be reare plans need t	when I I I I I I I I I I I I I I I I I I I	F 279				

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NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER			212 N 5	ESS, CITY, STAT FH AVE NY, KS 6700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 279	assessment. Facility failed to procare plan that revea	vide a clear comprehens led what type of service	s	F 279			
	hospice are to provide and to inform staff on the type of care provided. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.		CP	F 280			
	within 7 days after the comprehensive assignment of the resident, and disciplines as determined to the extent properties of the resident, the resident, the resident of the resident, the resident of the resi	are plan must be developme completion of the essment; prepared by arm, that includes the attered nurse with responsible other appropriate staff imined by the resident's reacticable, the participaticident's family or the resignant periodically reviews arm of qualified persons a	n nding illity in needs, on of dent's				
	The facility's census the sample. Based of interview the facility care plans were rev following significant	s not met as evidenced is totaled 29 with resident on record review and failed to ensure that resised in a timely manner changes or events (#12 re ulcers, and #4, #16, a	ident 2, for				

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	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE	•	
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F 280	Continued From page	e 11		F 280			
	Findings Included:						
	physician's order shemultiple sclerosis (MS nerve fibers of the brade of muscle, and muscle. Review of resident # Data Set) dated 11/22 had a BIMS (brief intescore of 15 which indimpairment. The resident extensive assistance personal hygiene, and assistance for toileting independent for eating resident used a wheel	16's annual MDS (Mining 2/13 revealed the reside erview of mental status) icated no cognitive lent required one persofor bed mobility, transfed dressing, and two persons and two persons are the same and two persons are the same are the sam	aled of the asm mum ent on ers, rson				
	08/25/14 revealed the of 15 which indicated The resident required assistance for bed mo personal hygiene, and dressing. The resident people for toileting. The independent for eating resident used a wheel resident had no falls at Review of the ADL (and (Care Area Assessment)) and to difficulties in the resident took anticological control of the ADL (and (Care Area Assessment)).	d two person assistance it was totally dependent he resident was g and locomotion. The I chair for locomotion. Since the last assessment it it it is a ctivities of daily living) (ent) dated 12/5/13 revealed epressants which could	e for t on 2 The ent. CAA aled				

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F 280	weakness. The resided potential for falls. The assistance of two per Review of the fall CAA the resident had weaknes with all transfers. The past, typically from resliding from his/her chunable to sit well with Review of the Care P the resident was at m to MS, muscle spasm The staff was to assist transfers. The staff was to assist transfers. The staff with make sure the call light transfers 2 staff would staff for other transfer not to wear shoes and resident used 2 cushin The care plan did not the fall on 11/3/14. Review of the nursing PM revealed the resident and the second control of the fall invested the resident and the second control of the fall invested the resident and the resident denied hitting Staff assessed the resident. Staff transfer obtained. Staff transfer	ent had an increased e resident had to have sons to transfer to the to the sons to transfer to the to the sons to transfer to the total december of the sons to transfer to the total for falls. The sond needed assistant resident had falls in the aching or dozing off an anair. The resident was out support. Ilan dated 09/03/14 revelopment of the resident for falls release, and muscle weakness the resident for all ere to anticipate needs the was within reach. For a participate for toilet us to the resident preferred wears socks only. The ons on his/her wheelch reveal any revisions aformation of the solution of the sol	ealed ealed lated ss. and rse, 1 ed e hair. fter 7:53 a her. hd twith hd the	F 280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E630		B. WING	 	12/1	0/2014
	OVIDER OR SUPPLIER COMMUNITY CARE	CENTER	212 N 5	RESS, CITY, STA TH AVE NY, KS 670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	
F 280	oriented. Factors that influenced the fall well incontinent and had a worsening, and the rerelieving cushion that during the transfer. The (director of nursing), a promptly. Review of the nursing revealed there were reand the vital signs well placed a new cushion chair. An interview with the PM revealed he/sher transfers and that he/without staff present. During an interview of direct care staff F revet transferred with a gair own. Toileting require resident with transferred could transfer the resident new and always used the staff interventions well quickly, and use a gall cushions in his/her will breakdown and when cushions and they slice changed the wheelch cushion. During an interview of the fall well included the wheelch cushion.	aring. The resident was a staff identified as having re; the resident was a diagnosis of MS which esident had a pressure was oversized and slice he administrator, DON and physician were not on injuries to the residence within normal limits. In the resident's whee president on 12/02/14 at required assistance with she never attempted it to belt and pivoted on his decreased to a sistence with the resident on 12/03/14 at 12:00 PM realed the resident to belt and pivoted on his decreased as a sistence with the sident if he/she used a giver got up on his/her ow call light appropriately, re to answer the call ligit belt. The resident required it.	ny was I out Ified Int Staff I 4:58 In The ht uired I with	F 280			
		of the wheel chair. The	ıı ıy				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/1	10/2014	
	OVIDER OR SUPPLIER COMMUNITY CARE	CENTER	212 N 5	RESS, CITY, STA TH AVE NY, KS 670				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	resident required one toileting. The resident cushion and had 2 at resident had not had a resident had not	staff for transfers and a now has just one thick the time of the fall. The any other falls. With a sorm the route cause and could be prevented. The interventions to the capting an investigation. The part of the capting an investigation of the capting an investigation. The part of the capting and investigation of the capting and investigation. The part of the capting and investigation of the capting and investigation of the capting and investigation. The part of the capting and investigation	e e e e e e e e e e e e e e e e e e e	F 280				
	order sheet dated 10/	diagnoses: esophage						
	Set) dated 5/29/14 re interview of mental st indicated moderate co	ion MDS (Minimum Da vealed a BIMS (brief atus) score of 8 which ognitive impairment. Th red assistance of 1 staf	ie					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI			E CONSTRUCTION	(X3) DATE SU COMPLE	
		17E630		B. WING		12/	10/2014
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
ANTHON	Y COMMUNITY CARE	E CENTER	212 N 5 ⁻ ANTHO	TH AVE NY, KS 6700	03		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	eating. The residen from his/her mouth we coughing or choking swallowing medicati difficulty or pain whe had a mechanically change in texture of Review of the cognit revealed the resider and required cueing resident had been or previous assessment adjusting to change dependence on staff (activities of daily liven Review of the nutriti revealed the resident of the assessment the resident on a diet. The difficulties and was also the term of the diet. The difficulties and was also the resident of an artery sided hemiparesis (in paralysis restricted the resident required as meals. Review of the signiff 10/6/14 revealed the of 14 which indicate resident required stameals. The assessment weight loss of 5% or loss of 10% or more	It had loss of liquids/solic when eating or drinking, a during meals or when lons, and complaints of en swallowing. The residulatered diet, and require food or liquids. Itive loss CAA dated 5/29 of had some cognitive de and time to answer. The ognitively intact during that and needed assistance. The resident did have the for much of his/her AD	and dent da 9/14 eficit e he ise total L etime the ving with CVA of eright vartial The with d core er d a or e	F 280			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C		` '	LE CONSTRUCTION	(X3) DATE SUI	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	ER:	A. BUILDING		COMPLET	TED
		17E630		B. WING		12/1	0/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ANTHONY COMMUNITY CARE CENTER			212 N 5 ANTHO	TH AVE NY, KS 670	03		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	regimen. Review of the resider 06/06/14 revealed the swallowing due to right staff were to monitor was to avoid lying doe eating and staff were elevated and encoura upright after meals. Stresident to avoid food to irritate the esophase chocolate, caffeine, a fried or fatty foods. All of the resident 's speneeds. The resident to Omeprazole, and Resprevention. An interveadded on 9/16/14 that could have regular for charge nurse if the reintervention to the car 11/20/14 that indicate receive Boost suppler daily. The facility failed to a weight loss after the wand failed to place he after the 6/23/14 order Review of the physici revealed the resident diet with puree consistiquids. Review of the physici Review of the physici revealed the	at 's care plan last revise resident had difficulty in the side hemiparesis, an for choking. The reside wn for at least 1 hour at to keep head of the beage the resident to standard which were to assist the last or beverages that tergeal lining such as; alcount of the side of the si	d ent fter d d nded ohol, d ned was y the g. An es r 7/14, e plan 4 ar ened	F 280			

NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES 212 N 5TH AVE ANTHONY, KS 67003 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PROVIDER'S PLAN OF CORRECTION SH	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
ANTHONY COMMUNITY CARE CENTER 212 N 5TH AVE ANTHONY, KS 67003 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 280 Continued From page 17 Review of the physician orders dated 9/18/14 revealed the resident's diet changed to a regular diet with pureed texture and thin liquids. Weight loss from 6/27 to 7/23 totaled 9.2% loss of the resident's body weight in one month. Interview on 12/04/2014 at 10:23 AM with licensed nursing staff E revealed if a resident had a weight loss the resident would be seen by the physician, and it would be included in the care plan meetings. Interview on 12/04/2014 at 11:23 AM with administrative nursing staff B revealed the facility did not do any preventative care for residents to prevent weight loss. Staff B was aware of the weight changes for resident # 12. Staff B reported he/she was responsible for monitoring the residents' weights and updating the care plans, as well as implementing interventions for weight loss.			17E630		B. WING		12/	10/2014
CALL DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG DEFICIENCES DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY F 280 Continued From page 17 Review of the physician orders dated 9/18/14 revealed the resident 's diet changed to a regular diet with pureed texture and thin liquids. Weight loss from 6/27 to 7/23 totaled 9.2% loss of the resident 's body weight in one month. Interview on 12/04/2014 at 10:23 AM with licensed nursing staff E revealed if a resident had a weight loss the resident would be seen by the physician, and it would be included in the care plan meetings. Interview on 12/04/2014 at 11:23 AM with administrative nursing staff B revealed the facility did not do any preventative care for residents to prevent weight loss. Staff B was aware of the weight changes for resident # 12. Staff B reported he/she was responsible for monitoring the residents' weights and updating the care plans, as well as implementing interventions for weight loss.	NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
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management staff D revealed he/she assisted with the tracking of the resident 's weights. A change of 2-3% in weight would be reported to the Director of Nursing. He/she verified that no supplements had been placed on the care plan until recently and that the nursing staff gave supplements. Review of the facility's policy Comprehensive Care Plans, dated 07/07/2001 revealed resident care plans would be reviewed every 90 days and if the resident experienced a significant change in physical condition. The facility failed to review and revise resident # 12 's care plan after weight loss had been identified on 6/27/14. The facility also failed to	F 280	Review of the physici revealed the resident diet with pureed texture. Weight loss from 6/27 the resident 's body with the tracking of the change of 2-3% in weight as well as implemental loss. An interview on 12/04/20 administrative nursing did not do any prevent weight loss. Sweight changes for rehe/she was responsible residents 'weights as well as implemental loss. An interview on 12/04 management staff Downth the tracking of the change of 2-3% in we the Director of Nursin supplements had been until recently and that supplements. Review of the facility's Care Plans, dated 07 care plans would be rif the resident experies physical condition. The facility failed to read the condition of the side of the condition.	ian orders dated 9/18/14 I's diet changed to a reure and thin liquids. It to 7/23 totaled 9.2% to weight in one month. In 14 at 10:23 AM with a resident would be seen by lid be included in the carbon of the care for residents. Staff B revealed the fact that it is a ware of the esident # 12. Staff B repole for monitoring the nd updating the care plain in the carbon of the esident for the carbon of the esident for weight would be reported the revealed he/she assisted the resident 's weights. A leight would be reported to the nursing staff gave to placed on the care plated the nursing staff gave as policy Comprehensive to placed on the care plated the nursing staff gave as policy Comprehensive to placed a significant chance weight loss had been are reviewed and revise reside weight loss had been are placed on the care plated the nursing staff gave.	egular coss of t had the re acility s to e corted ans, ight etary ed A to no lan e dent and nge in	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/	10/2014	
	OVIDER OR SUPPLIER COMMUNITY CARE	CENTER	212 N 5	RESS, CITY, STA TH AVE NY, KS 670	,			
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F 280	- Review of resident: (Minimum Data Set) of BIMS (Brief Interview 14, indicating no cognot exhibit rejection of the second secon	#4 's annual MDS dated 3/29/14 revealed for Mental Status) scor nitive impairment. He/sh f care. He/she required	a re of ne did	F 280				
	not exhibit rejection of care. He/she required extensive assistance of 1 staff for bed mobility. He/she required limited assistance for transfers, walking in the room/corridor, and locomotion on/off the unit. He/she did not have a steady balance, but was able to stabilize without staff assistance. He/she utilized a walker for mobility. The assessment indicated the resident had 1 minor injury fall.							
	Assessment) dated 4. had a recent fall, and feet. Resident #4 fell unassisted and without on 3/6/14. Resident # difficulty moving with	I's Fall CAA (Care Are /12/14 revealed resider I was unsteady on his/htrying to toilet him/herseut his/her walker. He/shi4 was unbalanced and assistance and a walketiple diagnoses that courties.	nt #4 ner elf ne fell had er.					
	Functional Status CA resident #4 required a bathing, and transfers of assistance, and the #4 had some cognitiv difficulty. Resident #4 weakness. He/she us	ctivities of daily living) A dated 4/12/14 revealers assistance with ADLs, as due to imbalance, the error use of a walker. Residue loss and communicate had physical limitations and a walker for ambulations and balance as	need dent tion s and tion					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E630		B. WING		12/10/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•
ANTHONY COMMUNITY CARE CENTER			212 N 5 ⁻ ANTHO	TH AVE NY, KS 670	03	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 280	times. The resident restaff to ambulate and walker. The resident for transfers and at the assistance. Review of the quarter revealed a BIMS scocognitive impairment. rejection of care. Heleassistance of 1 staff the walking in the room/of the unit. He/she requiled locomotion off the uniteady balance and vistaff assistance. He/s mobility. The assessing had not had any falls. Review of resident #41/27/14 revealed the risk for falls related to use, osteoporosis (a that is characterized and density which ca fracture), and poor baincluded to anticipate needs, ensure his/he and encourage the reassistance as needed prompt response to a The care plan was not resident #4 's falls or Review of resident #4 physical mobility date resident required 1 stand he/she used an a four-wheeled walker.	equired the assistance of used a four-wheeled required stand-by assisted mes required hands on a standard programmer of 12, indicating modern of 14, and locomotion in the standard of 15 can be used a walker for ment indicated the resident was at modern of 15 can be used a walker for ment indicated the resident was at modern of 15 can be used an increased in an and meet the resident recall light was within resident to use it for 15 can be used or revised and 16 can and 17 can be used or revised or revised of 17 can be used the taff participation for modern or 15 can be used to 17 can be	derate rs, on a e with dent t. ated ate alker sse mass risk of ' s ach ce. ffter	F 280		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/1	0/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ANTHON	COMMUNITY CARE	CENTER		TH AVE NY, KS 670	03		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR) OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	current level of assists. Review of an Incident 3/5/2014 at 6:35 p.m. called to resident #4' was found lying on the dresser. Resident #4 corner of the dresser requiring sutures. Review of a Fall Invest revealed at 6:35 p.m. called to resident #4's #4 laid on the floor in resident had hit his/he causing a laceration to requiring sutures. The he/she got up to go to balance causing his/he ambulated without as wheeled walker. The toileted. The walker herecliner and the reside blankets on him/her applaced in his/her hand resident. Review of an Incident 2:08 p.m. revealed rebed during the night. The time of the incident deny pain or any conductive thallway towards his/he and he/she had a steady to the side of the side of the had a steady towards his/he and he/she had a steady towards his/here.	ance with mobility. Note Late Entry dated revealed the staff was a room and the resider of floor in front of his/he had hit his/her head on causing a laceration of stigation dated 3/5/14 on 3/5/14 the nurse was room by the aide. Resigned front of his/her dresser of the top of his/her scale resident reported that of the bathroom lost his/her fall. The resident sistance using his/her resident had just been ad been placed beside ent was in the recliner with the floor of his/her call light was different or covering the sident #4 rolled from his He/she had no injuries hit. The resident continuous on 12/3/14 at 2:19 p.m. di independently down the room with his/her was ady gait.	r the as ident . The lp her the s/her at ed to n. he alker	F 280			
	_	n 12/3/14 at 9:37 a.m. o esident #4 was at risk f					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O			E CONSTRUCTION	(X3) DATE SU COMPLE	
		17E630		B. WING	<u> </u>	12/	10/2014
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER			212 N 5	ESS, CITY, STAT TH AVE NY, KS 6700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	falls. Staff J reported resident to use his/h resident #4 often am assistance. Staff J re resident #4 ambulati stopped to assist the resident #4 had a sh difficulty steadying h During an interview care staff I reported resident was at risk interventions to previncluded wearing shonon-slip socks and hused a walker all the he/she was very wolhim/her to use that ambulated independ staff to assist him/her resident did not need because he/she was Staff I confirmed on plan accessible to the required 1 staff partineeded to help resident needed help During an interview licensed nursing staff a walker, transferred independently. Staff prevent resident #4 sure the path between staff knew which resistaff	I he/she encouraged the er call light. Staff J reported if he/she observing without assistance he resident. Staff J report aky balance at times arim/herself. In 12/3/14 at 2:27 p.m. he/she was unaware if the for falls. He/she reported ent resident #4 from fall ones with a non-slip sole resident ent resident the resident he/she reported the residently, but did sometime er. Staff I reported the entity, but did sometime er. Staff I reported the entity, but did sometime er. Staff I reported the did to call for assistance independent with transiting the kardex (electronic content and the content and the content and the resident the entity. Staff I reported the entity. Staff I reported the content and the content and ambulated in the resident and ambulated in the resident and the of clutter. Staff E reported care placetis in the resident and the of clutter. Staff E reported care placetis in the resident and the of clutter. Staff E reported care placetis in the resident and the of clutter. Staff E reported care placetis in the resident and the of clutter. Staff E reported care placetis in the resident and the of clutter. Staff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E reported care placetis were at risk for fastaff E repor	rted ed ee/she ed id had direct the d ing and dent raged ident s ask fers. are 4 uff I r staff e 4 was used tion to king d the alls	F 280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE S COMPLE	
		17E630		B. WING		12/	/10/2014
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER 212 N 5TH AVE ANTHONY, KS 67003							
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F 280	a way to see if the of the falls to ensure the falls to ensure the interventions to prevent the falls to ensure the staff B on 12/4/14 at November 2014 the to ensure fall investible beyond reading the not identified, or the interventions. Staff B aware of the fall on a resident to have loss Staff B reported the walker and if he/she required stand-by as resident #4's care following his/her falls needed to be update was independent. Sexpected the care pfall and if the resider assistance. Although requested to provide a policy replans. The facility failed to 's care plan following plan to reflect the rerequired for mobility.	was not positive if there are plan was reviewed and care plan included went the fall from recurring with administrative nursing to 11:59 a.m. revealed pring facility did not have a syngations were completed nurse notes, root cause care plan updated with a reported the staff were plan updated with a reported the staff was determined by this/her balance and fell resident ambulated with a had far to walk he/she assistance. Staff B confirm plan was not updated as and reported the care plan to be updated following the had a change in ADL on 12/4/14 the facility faregarding the revision of careview and revise resident assistant.	or to stem was fall not root by the a ned plan dent wing a iled care ent #4 care ince	F 280			
		4 revealed the following ers disease (progressive	:				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		l` ′	E CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E630		B. WING		12/1	0/2014
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER			STREET ADDRI 212 N 51 ANTHON				
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F 280	mental deterioration characterized by confusion and memory failure) - Review of the comprehensive admission MDS			F 280			
	he/she had long term impairment. The resi unclear and usually r understood by others had wandering behar assistance of one sta daily living). He/she	s. This revealed the resi viors. He/she required a off with ADLs (activities used a walker for ambu e during transfer and w	y as Ident an of Ilation				
	Review of the fall CAA (care area assessment) dated 11/4/14 revealed the resident was at increased risk for falls due to his/her dementia diagnosis, hearing and vision deficit as well as the need for assistance with ambulating by using a walker. Review of the ADL/Function CAA dated 10/30/14 revealed the resident ambulated with walker and required assistance with dressing and at times toileting and hygiene.		tia as the				
			and				
	10/6/14, revealed to wandering by offering structured activities, television, book. The visit and possibly war Review of the resider revealed he/she used to ambulate. Staff war risk for falls.	resident preferred: to s	it and B/4/14 alker sed				

	PLAN OF CORRECTION (X1) PROVIDER/SUPP IDENTIFICATION I			1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/10/2014	
	OVIDER OR SUPPLIER Y COMMUNITY CARE	CENTER	212 N 5	ESS, CITY, STA TH AVE NY, KS 670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 280	7/16/14, revealed staff was to ensure that he/she wore appropriate footwear such as shoes and socks or non-skid socks when ambulating. Review of the incident note dated 11/25/2014 at			F 280			
	12:26 AM revealed that staff had removed all socks without grippers due to the 2nd fall while wearing this type of sock on a hard wood floor without shoes.						
	AM revealed the nursanother resident's rowalker being moved is staff observed the reside on the floor with him/her. The resident the south wall of her him/herself up off the regular socks that we floor. The resident inibed but a few minute not fall out of bed and "twisting and turning bed." The resident m sitting position before assist in getting him/hore weight, assist an lifted him/her up to the wear slip gripper sock obtained a pair of nor resident's feet.	It's head was pointed to groom. He/she tried to groom. He/she tried to groom. The resident worker slick on the hard working the slick on the hard working the slater he/she stated the slater he/she stated the stated he/she had been and twisting and turning oved him/herself into a sea a second person arrivener off the floor. The resident did was at the time of fall. Stanslip gripper sock to the	m d of a The eft wards eet ee ood oout of ey did en g in ed to sident aff not aff				
	6:51PM revealed star in front of the recliner chair. The resident hat found during assessr	at note dated 10/22/201 if found the resident known in his/her room facing ad no red areas or injuri nent. ant report dated 10/22/1	eeling the ies				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E630		B. WING		12/10/2014
	OVIDER OR SUPPLIER Y COMMUNITY CARE	CENTER	212 N 5	ESS, CITY, STA FH AVE NY, KS 670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION
F 280	revealed same inform resident #21 wore im Interview with license 12/03/2014 at 2:29 P had a fall the change charge nurse and the leave his/her socks or did not show that resistance with direct of 3:30 PM revealed the the resident needed hiving. The resident won a movie or had the that family had broug wandered in the facilia. Interview with direct of 10:03 AM revealed the assistance with dress walker behind and wo him/her into the tv root took off his/her shoes random places. He/sl his/her shoes. Interview with adminital/4/14 at 8:40 AM reupdated every quarter identified falls and sign provide non-skid socks. Interview and also on staff of the change. T	nation as nursing note a proper footwear. In a dinursing staff E on M revealed when a resiplan is changed with the DON. He/she would not a shoes on. The care platent did not leave his/hor care staff I on 12/03/14 to resident was confused and the resident was confused and the resident read newspath to the resident read newspath when the resident form. The resident sometical she wore non-skid socks the wore non-skid socks the wore non-skid socks the staff can direct of the resident change. The facts for the residents. Staff his/her with all new went on were placed on the message board to the resident did not like on. Staff B staff d staff B staff	ident ne ot an ner at d and nilly en put pers at t the t cimes in s with on e ncility aff the notify to	F 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	- CORRECTION	IDENTIFICATION NUMBE	K.	A. BUILDING		COMPLET	ED
		17E630		B. WING		12/1	0/2014
	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
ANTHON	COMMUNITY CARE	CENTER		TH AVE NY, KS 670	03		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	Continued From page 26			F 280			
	Review of the facility's policy Comprehensive Care Plans, dated 07/07/2001 revealed resident care plans would be reviewed every 90 days and if the resident experienced a significant change in physical condition.						
		eview and revise reside is/her fall on 10/22/14.	nt#				
	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES		F 323				
	as is possible; and ea	as free of accident haz					
	The facility had a cen in the sample and 3 re Based on observation review the facility faile fall prevention strateg	not met as evidenced be sus of 29 residents with eviewed for accidents. n, interview, and record ed to initiate the appropries to prevent future fall ate falls for 2 of 3 resident	n 16 oriate Ils				
	Findings included:						
	orders dated 10/1/14 diagnoses: Alzheimer	nt #21's signed physicia revealed the following r's disease (progressive characterized by confus	:				
	Review of the compre	ehensive admission ME	os				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBE	:K:	A. BUILDING		COMPLE	ED	
		17E630		B. WING		12/1	0/2014	
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE			
				TH AVE NY, KS 670	03			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	(minimum data set) dhe/she had long term impairment. The residunclear and usually mby others. This reveal wandering behaviors assistance of one stated daily living). He/she cand residents balance is steady at all times. Review of the fall CA dated 11/4/14 reveal increased risk for falls diagnosis, hearing anneed for assistance walker. Review of the ADL/Furevealed the resident required assistance would to increase the resident required assistance would be revealed the resident required assistance would the resident required activities, for television, book. The visit and possibly wat Review of the resident revealed he/she used to ambulate. Staff warisk for falls. Review of the resident revealed the resident revealed he/she used to ambulate. Staff warisk for falls. Review of the resident revealed start revealed revealed start reveal	ated 10/30/14 revealed and short term memory dent's speech clarity was hade him/herself undersided the resident had He/she required an ff with ADLs (activities of used a walker for ambure during transfer and was a due to his/her dement distontion CAA dated 10/3 ambulated with ambulating by using function CAA dated 10/3 ambulated with walker with dressing and at time with distract the resident from a pleasant diversion, nood, conversation, resident preferred: to sight TV. It's care plan, initiated to a assistive devices was so monitor for increas and the such as shoes and the such as sho	y is stood of lation alking ont) ia as the g a sold and es on it and side alker ed e/she	F 323				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			E CONSTRUCTION	(X3) DATE S COMPLE	
		17E630		B. WING		12	/10/2014
	ROVIDER OR SUPPLIER Y COMMUNITY CAR	E CENTER	212 N 5	RESS, CITY, STAT TH AVE NY, KS 6700			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	Review of the incident of 12:26 AM revealed socks without grippy wearing this type of without shoes. Review of incident of AM revealed the nutle another resident's rewalker being moved staff observed the reside on the floor with him/her. The resident the south wall of he him/herself up off the regular socks that of floor. The resident of the bed but a few minute that the south wall of bed a "twisting and turning bed." The resident of assist in getting him bore weight, assist lifted him/her up to wear slip gripper so obtained a pair of nesident's feet. Review of the incident of the reclination of the accident of the a	ent note dated 11/25/201 that staff had removed a ers due to the 2nd fall wh sock on a hard wood flo note dated 11/13/2014 at rse was coming back fro com and heard the soun d in the resident's room. esident lying on his/her l h his/her walker facing nt's head was pointed to r room. He/she tried to gree slick on the hard wo nitially stated he/she fell tes later he/she stated th nd stated he/she had be grand twisting and turning moved him/herself into a re a second person arriv hard for the floor. The re and counted 1, 2, 3 as s the bed. The resident did cks at the time of fall. St on-slip gripper sock to the ent note dated 10/22/201 aff found the resident kn er in his/her room facing had no red areas or injurisment. dent report dated 10/22/20 remation as nursing note a	all hille hor. t 1:12 ym d of a The eft wards get re hood out of ey did en g in ed to sident taff d not raff he eling the ries 14 at eeling the ries 14 and	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		, ,	LE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN O	CORRECTION	IDENTIFICATION NUMBE	R:	A. BUILDING		COMPLET	COMPLETED	
		17E630		B. WING		12/1	0/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
ANTHON	COMMUNITY CARE	CENTER	212 N 5 ANTHO	TH AVE NY, KS 670	03			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page	e 29		F 323				
	resident ambulated with walker and had a steady gait with shoes on both feet. Observation on 12/02/14 at 3:05 PM revealed the resident walked with the walker and wore shoes on both feet. The resident ambulated without the walker and left the walker by the cabinet in the							
		dent had steady gait as						
	Observation on 12/02/14 at 3:11 PM revealed he/she stood up independently from the chair. Staff assisted the resident with getting something to drink.							
	Interview with licensed nursing staff E on 12/03/14 at 2:29 PM revealed when a resident had a fall the care plan is changed with the charge nurse and the DON. He/she would not leave his/her socks or shoes on. The care plan did not show that resident did not leave his/her socks or shoes on.							
	3:30 PM revealed the the resident needed h living. The resident was		d and ily en put					
	10:03 AM revealed th assistance with dress walker behind and wo him/her into the tv roo	care staff K on 12/4/14 are resident needed sing. He/she often leave onders if staff can direct om. The resident somet and placed the shoes	the imes					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING	<u>.</u>	12/1	10/2014
ANTHONY COMMUNITY CARE CENTER 21			212 N 5	RESS, CITY, STA TH AVE NY, KS 670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETION DATE
F 323	random places. He/sh his/her shoes. Interview with administ 12/4/14 at 8:40 AM reupdated every quarte identified falls and sigprovide non-skid sock had just replaced all conon-skid socks. Intervare plan and also on notify staff of the chart to keep sock or shoes he/she was behind or Review of the facility incidents, last revised accidents or incidents employees, visitors very premise must be inveadministrator. The facility failed to eccausative factors and	strative nursing staff B of evealed care plans were r, annually, when staff inificant change. The facts for the residents. Staff his/her with all new vention were placed on the message board to nige. The resident did not son. Staff B stated that in updating the careplant policy for accidents and 17/10/14, revealed all is involving residents, endor, etc., occurring or stigated and reported to valuate resident #21 fall develop an individualization are possible to provention.	cility iff the ot like s.	F 323			
	BIMS (Brief Interview 14, indicating no cogn not exhibit rejection o extensive assistance He/she required limite walking in the room/c on/off the unit. He/she	#4 's annual MDS dated 3/29/14 revealed for Mental Status) scor nitive impairment. He/sh f care. He/she required of 1 staff for bed mobili ed assistance for transfe orridor, and locomotion e did not have a steady e to stabilize without sta	re of ne did ty. ers,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E630		B. WING		12/10/2014
	OVIDER OR SUPPLIER Y COMMUNITY CARE	CENTER	212 N 5	RESS, CITY, STA TH AVE NY, KS 670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION
F 323	assistance. He/she use the assessment indiminor injury fall. Review of resident #4 Assessment) dated 4 had a recent fall, and feet. Resident #4 fell unassisted and without on 3/6/14. Resident #4 difficulty moving with The resident had multiple factor of the ADL (as Functional Status CA resident #4 required a bathing, and transfers of assistance, and the #4 had some cognitive difficulty. Resident #4 weakness. He/she used to decreased most times. The resident restaff to ambulate and walker. The resident for transfers and at times assistance. Review of the quarter revealed a BIMS scocognitive impairment. rejection of care. He/sassistance of 1 staff of walking in the room/of the unit. He/she required to comotion off the unsteady balance and wastaff assistance. He/sassistance.	tilized a walker for mob cated the resident had a large of the resident had a large of the state	ea ent #4 ener elf ene fell had er. uld ed ed ent tion es and ettion estance elerate ers, e on ee with	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY	
AND PLAN O	- CORRECTION	IDENTIFICATION NUMBE	:R:	A. BUILDING		COMPLE	IED	
		17E630		B. WING		12/	10/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANTHON	COMMUNITY CARE	CENTER		TH AVE NY, KS 670	N3			
			ANTIIO	1			(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 32		F 323				
	had not had any falls	since prior assessment	t.					
	Review of resident #4 1/27/14 revealed the risk for falls related to use, osteoporosis (a pthat is characterized by and density which car fracture), and poor basincluded to anticipate needs, ensure his/her and encouraged the reassistance as needed prompt response to a Review of resident #4 physical mobility date resident required 1 st and he/she used an a four-wheeled walker of the Review of the fall risk revealed a score of 9 at moderate risk for fall risk revealed to resident #4 was found lying on the dresser. Resident #4 corner of the dresser requiring sutures. Review of a Fall Investorevealed at 6:35 p.m.	s's care plan for falls deresident was at moderal decreased mobility, was progressive bone diseably a decrease in bone on lead to an increased of alance. Interventions and meet the resident or call light was within referenced in the resident of the resid	ated ated ate alker se mass risk of 's ach ce. d billity 27/13 was					
	resident had hit his/he causing a laceration t	front of his/her dresser er head on the corner o the top of his/her sca e resident reported that	lp					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12 <i>l</i> ·	10/2014	
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER		CENTER	212 N 5	ESS, CITY, STA TH AVE NY, KS 670		•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	he/she got up to go to balance causing his/h ambulated without as wheeled walker. The toileted. The walker h recliner and the reside blankets on him/her a placed in his/her hand resident. Review of a fall risk a revealed a score of 7 at moderate risk for fall risk a revealed a score of 9 at moderate risk for fall risk fall risk fall risk for fall risk fall risk fall risk for fall risk f	o the bathroom lost his/her fall. The resident sistance using his/her resident had just been ad been placed beside ent was in the recliner wind his/her call light was diprior to covering the ssessment dated 3/28/h, indicating resident #4 alls. It Note dated 7/8/2014 a sident #4 rolled from his He/she had no injuries hit. The resident continuctorn. assessment dated 9/2/fore of 8, indicating modern. assessment dated 9/2/fore of 8, indicating modern.	the with s 14 was 14 was 14 was 15/her at 16/her at 16/h	F 323				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI			CONSTRUCTION	(X3) DATE S COMPLE	
		17E630		B. WING		12	/10/2014
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER		E CENTER	212 N 5	RESS, CITY, STATE TH AVE NY, KS 67003			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	stopped to assist the resident #4 had a ship difficulty steadying had been care staff I reported resident was at risk interventions to previncluded wearing shonn-slip socks and hused a walker all the he/she was very wo him/her to use that, ambulated independent staff to assist him/her resident did not nee because he/she was Staff I confirmed on plan accessible to the required 1 staff particeported 1 needed held. During an interview licensed nursing staff a walker, transferred independently. Staff prevent resident #4 sure the path betwee bathroom was free cafter a resident fell, Nursing, and the Ad cause of the fall and E reported the staff risk for falls from the An interview with ad	e resident. Staff J report haky balance at times ar him/herself. on 12/3/14 at 2:27 p.m. he/she was unaware if the for falls. He/she reported went resident #4 from fall hoes with a non-slip sole he/she reported the resident because at times of the because at times of the because at times of the he/she reported the residently, but did sometime er. Staff I reported the residently, but did sometime er. Staff I reported the resident with transiting the kardex (electronic cone aides) that resident #4 icipation for mobility. Staficipation meant 1 aide of dent #4 with whatever the point with the with the resident #4 if E reported the resident #4 if E reported the intervention from falling included material the resident and the of clutter. Staff E reported the intervention from falling included material the resident and the of clutter. Staff E reported the intervention in the properties of the point of the horizontal the care plantal knew which residents with the residents which residents with the residents which residents which residents with the residents which residents which residents with the residents which residents	direct the d ling and dent lraged ident s ask fers. are 4 aff I r staff e 4 was used tion to lking ed of r root Staff ere at	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E630		B. WING		12/	10/2014		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	I RESS, CITY, STA	TE, ZIP CODE	I			
				N 5TH AVE HONY, KS 67003					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	2014 the facility did n fall investigations wer the nurse notes, root the care plan updated B reported the staff w 7/8/14. He/she report on 3/5/14 was determ lost his/her balance a resident ambulated w had far to walk he/she assistance. Review of the facility incidents, last revised were reported to the completed for all report when information of slearned. An Accident completed for all report he nurse supervisor department director of immediate investigation incident. The completed Report Form was sub Nursing Services no loccurrence of the according to the facility failed to incresident #4 to identify 483.25(i) MAINTAIN INTESS UNAVOIDA Based on a resident's assessment, the facility resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that this demonstrates that this	ot have a system to entere completed beyond recause was not identified with fall interventions. Here not aware of the fated the root cause of the inned by the resident to not fell. Staff B reported ith a walker and if he/s the required stand-by I's policy for Accidents I 07/2014, revealed incident was discovered accident was discovered accident was discovered accident for incident Report Formation of the accident or incident or incident or incident or incident or incident or incident or incident. Investigate all falls for the root cause of the faccident or incident. Investigate all falls for the root cause of the faccident or incident. Investigate all falls for the root cause of the faccident or incident. Investigate all falls for the root cause of the faccident or incident. Investigate all falls for the root cause of the faccident or incident. Investigate all falls for the root cause of the faccident or incident. Investigate all falls for the root cause of the faccident or incident. Investigate all falls for the root cause of the faccident or incident.	eading ed, or Staff II e fall have d the he and idents as red or vas m was ents. ne I an on of r the	F 325					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
AND PLAN O	CORRECTION	BENTI TOATTON NOMBER.		A. BOILDING	7. BOILEDING		OOWII EETEB	
		17E630		B. WING		12/1	0/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
ANTHONY	COMMUNITY CARE	CENTER		TH AVE NY, KS 670	03			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 325	Continued From page nutritional problem.	e 36		F 325				
	The facility's census t sampled for nutrition.		nts					
	Findings included:							
	- Review of resident #12's signed physician's order sheet dated 10/13/14 revealed the following diagnoses: esophageal reflux (backflow of stomach contents to the esophagus).							
	Set) dated 5/29/14 reinterview of mental stindicated moderate coresident required limit eating. The resident from his/her mouth who coughing or choking of swallowing medication difficulty or pain when	atus) score of 8 which ognitive impairment. The dassistance of 1 stafthad a loss of liquids/sothen eating or drinking, during meals or when ans, and complaints of a swallowing. The resident diet, and required	ie f for lids and ent					
	revealed the resident and required cueing a resident had been co- previous assessment	ve loss CAA dated 5/29 had some cognitive de and time to answer. The gnitively intact during the and needed assistance. The resident did have to	ficit e ne e					

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E630 B. WING 12/10/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER **212 N 5TH AVE** ANTHONY, KS 67003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 F 325 Continued From page 37 dependence on staff for much of his/her ADL (activities of daily living) care. Review of the nutritional CAA dated 5/29/14 revealed the resident was overweight. At the time of the assessment the physician did not put the resident on a diet. The resident had swallowing difficulties and was being seen by speech therapy. The resident was on a pureed diet with honey thickened liquids. He/she had a PEG (percutaneous endoscopic gastrostomy) tube (a tube placed into a person 's gastrointestinal system that can be utilized for receiving nutrition and/or medications) in place as well. The resident had a CVA (Cerebrovascular accident - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) resulting in right sided hemiparesis (muscular weakness or partial paralysis restricted to one side of the body). The resident received honey thickened liquids and a pureed diet. The resident required assistance and monitoring with meals. Review of the significant change MDS dated 10/6/14 revealed the resident had a BIMS score of 14 which indicated cognitively intact. The resident required staff supervision/set up for meals. The assessment revealed he/she had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The resident was not on prescribed weight-loss regimen. Review of the resident's care plan last revised 06/06/14 revealed the resident had difficulty swallowing due to right sided hemiparesis, and staff were to monitor for choking. The resident was to avoid lying down for at least 1 hour after eating and staff were to keep the head of the bed elevated and encourage the resident to stand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/	10/2014
	OVIDER OR SUPPLIER Y COMMUNITY CARE	CENTER	212 N 5	RESS, CITY, STA TH AVE NY, KS 670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 325	upright after meals. So resident to avoid food irritate esophageal lin chocolate, caffeine, a fried or fatty foods. All of the resident 's speneeds. The resident to Omeprazole, and Resprevention. An intervention to the 9/16/14 that indicated regular foods. Staff where we will be the end of the e	staff were to assist the las or beverages that ter ing such as; alcohol, cidic or spicy foods, an I staff were to be information cial dietary and safety ook the medications glan for gastric reflux Care Plan was added I the resident could havere to notify the charge exhibited choking. Care Plan was added difference to the resident should ment shakes three times an orders dated 6/23/14 should receive a regulation orders dated 6/23/14 was to have health shattion administration received a revealed the health No order was found found the shakes were not in until 11/20/14. Can orders dated 9/18/14 an orders dated 9/18/14 and thin liquids.	d ned on e e e e e e e e e e e e e e e e e e	F 325			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
17E630			B. WING		12/10/2014			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE. ZIP CODE			
	Y COMMUNITY CARE	CENTER	212 N 5		,			
7				NY, KS 670	03			
(X4) ID PREFIX TAG			GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 325	Continued From page	e 39		F 325				
F 323	Continued From page 39 physician's order dated 10/6/14 for health shakes three times daily. Review of the MAR revealed the health shakes were given as ordered after 10/6/14.		F 323					
	Review of the residen	nt's weights revealed:						
	Review of the register 6/20/14 revealed the pureed foods per nurs (certified nurse aides) resident to take puree for the resident include	lbs lbs lbs lbs lbs lbs m 6/27 to 7/23 of 9.2%	eds					
	6/24/14 revealed the the hospital on 6/23/1 which was down 23.4 hospital. Also the resimodified to a puréed The resident did not lidid okay with the puréback at the facility. Review of the register 7/7/14 revealed the resident did the resident did not lidid okay with the puréback at the facility.	red dietician note dated resident had returned fi 4 with a weight of 161. Ibs since going in to the dent's diet had been diet with thickened liquidated texture at the first noted dietician note dated esident required poor meal intake of pure	rom 2 lbs, e ds. s, but neal					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CAND PLAN OF CORRECTION IDENTIFICATION NUMB			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E630		B. WING		12 <i>l</i> ·	10/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	FE, ZIP CODE		
ANTHON	Y COMMUNITY CARE	CENTER	212 N 51 ANTHOI	TH AVE NY, KS 6700	03		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	diet with honey thick the resident to eat. This/her food preferer Review of the registed dated 11/30/14 reveal weight increase of 7. history of weight variant medication use. The for feeding himself/h pureed meals. The reinadequate fluid intal ADLs, diuretic use, las swallowing with a history of incontinence, and we related to a history of incontinence, and we received nutrition she encouraged the resident grams of protein and daily. The dietician repureed diet with PEC continue as ordered. During an observation revealed the resident gravy with a biscuit, water, and juice. The the breakfast. An interview on 12/3 resident revealed the and Mexican foods. In order alternatives and he/she wanted. He/she wanted. He/she receive the Breeze here.	liquids. Staff encourage the resident could make been could make and the resident had a some the resident had a some the resident had a some the resident was independent was independent was at risk for the related to total care for the resident was at risk for the related to total care for the required increased as at risk for skin breaker to the required increased as at risk for skin breaker to eat well. Nutrition the were; 1650 calories well 2,366 milliliters of water to the regular of the flushes and shaker the resident and s	ent ular for ty d I down nal with 55 er es to M sage uce, 0% of ased icken did thing es a	F 325			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		LIA ,		ILDING		(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/1	0/2014
	OVIDER OR SUPPLIER			ESS, CITY, STAT	FE, ZIP CODE		
ANTHON	Y COMMUNITY CARE	E CENTER	212 N 51 ANTHO	TH AVE NY, KS 6700	03		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	An interview on 12/3 care staff H revealed resident had ever had reported the resident like it, and the resident #12. Staff I responsible for mon and updating the ca implementing intervestaff were aware of changes and were cresidents received for resident #12 received liquids and that the resident liquids and the resident liquids and the resident liquids and the resident liquids and the resident liquids. The resident had the resident would be included. During an interview dietary management.	ame to the facility. 3/14 at 11:49 AM with did the/she did not know the ad any weight loss. Staff thad a puree diet but die that received thin liquids. 3/14 at 11:23 AM with the staff B revealed the face that ive care to prevent ware of the weight chang the replans, as well as the replans, as well as the resident # 12 's weight locumenting. Some of the ordified foods. Staff B replanded the face that we have a supplementation of the resident did not like the face and a pureed diet with thic resident did not like the face and a pureed diet with the face and the face	d not acility weight es for eights The be corted ck food staff B ents at had iet, Staff e peg s. ss , and gs. with aff did	F 325	DEFICIENCY)		
	tube. The resident h solids since around Staff E reported if a the resident would b it would be included During an interview dietary managemen not use a breakout r	ad progressed to eating October, with thin liquid resident had a weight love seen by the physician in the care plan meeting on 12/04/14 at 5:00 PM	s. ss , and gs. with aff did				

l' '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/1	0/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
ANTHON	COMMUNITY CARE	CENTER	212 N 5	TH AVE			
			ANTHO	NY, KS 670	03		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	,	ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP		COMPLETION DATE
					DEFICIENCY)		
F 325	Continued From pag	e 42		F 325			
	getting enough nutriti	on. Staff D reported he	/she				
	assisted with the trac	king of the resident 's					
	weights. Staff D repo	rted staff checked the					
	_	eekly. A change of 2-3	% in				
		orted to the Director of					
		rted the facility did not					
	•	c foods or diets. Staff D	I				
		onsidered a fortified for					
	•	when the registered die	etician				
	rounds in the facility,						
		supplements, and staf					
		nakes and resource juic	I				
		nal assessments were					
		orted not all resident we	-				
		kly. Staff D reported res ed liquids or pureed foo					
		d assistance with feeding					
	=	elf/herself. He/she verific	-				
		had been placed on the					
		d that the nursing staff					
		was aware of the resid	-				
		orted the resident was					
	•	r his/her ideal body wei	I				
	Interview on 12/8/14	-					
		g staff B revealed the o	rder				
		been resumed on 6/23	I				
	when the resident ret	urned from the hospital	l.				
	Staff reported the res	ident did receive					
	supplement shakes a	after his/her return from	the				
	hospital, but there wa	as no documentation to	show				
		them. Staff B reported	that				
	on the electronic MAR, the order was not						
		he order being placed o					
		ned. This continued unt	ıı a				
	second order was wri	itten on 10/6/14.					
	During an interview o	on 12/8/14 at 12:15 PM					
		he/she had been made	,				
		ad weight loss. Physicia					
	reported the resident	had orders for a nutrition	onal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12/1	10/2014	
	OVIDER OR SUPPLIER Y COMMUNITY CARE	CENTER	212 N 5	RESS, CITY, STATE TH AVE NY, KS 670		•		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA			ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 325	supplement to prever physician was not aw been receiving the su 10/6/14. The facility failed to p supplements to prever	nt further weight loss. The are the resident had no applements from 6/23/14	ot 4 to	F 325				
F 371 SS=F	STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	ERVE - SANITARY a sources approved or ry by Federal, State or stribute and serve food		F 371				
	The facility reported a Based on observation review the facility failst temperatures for food. Findings included: - An observation on staff L measured the pulled pork on the stetemperature of 125 dc L reported he/she like temperatures of 160 d times complained that turned the temperature began to plate the pulled no based on the stemperature of 160 dc times complained that turned the temperature began to plate the pulled no based on the stemperature of 160 dc times complained that turned the temperature began to plate the pulled no based on the stemperature of 160 dc times complained that turned the temperature began to plate the pulled no based on the stemperature of 160 dc times complained that turned the temperature began to plate the pulled no based on the stemperature of 160 dc times complained that turned the temperature began to plate the pulled no based on the stemperature of 160 dc times complained that turned the temperature began to plate the pulled no based on the stemperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the temperature of 160 dc times complained that turned the turned the turned the turned that turned the turned the turned that turned the turned the turned that turned the turn	12/3/14 at 11:04 a.m. d temperature of barbecu am table. He/she obtai egrees Fahrenheit (F).	ietary ue in a Staff 's at e aff L					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		17E630		B. WING		12	10/2014	
NAME OF PF	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANTHON	Y COMMUNITY CARE	CENTER		TH AVE NY, KS 670	03			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 371	table were between 4 degrees F. Staff L repplaced the pulled port the oven the steam taits temperature so he more pulled pork until On 12/3/14 at 11:29 at temperature of the put temperature of 120 de that he/she would turn steam table and see of the put temperature of 120 de dietary staff F for assisted on 12/3/14 at 11:37 at temperature of 120 de dietary staff F for assisted on 12/3/14 at 11:43 at the holding temperature between 135-145 staff L to put the pulle heat and bring it up to bowl and microwave would need to measure till the staff reconstruction or if the staff reconstruction or if the staff reconstruction of the staff L should have real holding temperature obtained. On 12/3/14 at 11:55 per temperature of the put the pulled to the put the pulled to the staff reconstruction.	or food items on the stead of the stead of the steam table of the stea	d just from ned e any ature. ne a ed n the ne a d orted hould ructed low n a e/she eh F	F 371				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER 1				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E630	1	B. WING		12	/10/2014
	ROVIDER OR SUPPLIER Y COMMUNITY CAR	E CENTER	212 N 5	RESS, CITY, STATE TH AVE NY, KS 6700			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	Although requested to provide a policy r temperatures. The facility failed to table was in accept	age 45 If on 12/4/14 the facility faregarding food holding to ensure food on the steal able temperature ranges into the prevent food-borner.	am s prior	F 371			